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No. 06-923

IN THE

Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY), ET AL.,
Petitioners,
v.
WANDA GLENN,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF FOR THE BLUE CROSS AND BLUE SHIELD ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONER

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INTEREST OF THE AMICUS CURIAE

The Blue Cross and Blue Shield Association ("BCBSA") is the national association of Blue Cross and Blue Shield companies. It comprises thirty-nine independent, locally owned Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield companies, through relationships with federal, state, and local government entities, employers, employee benefits plans, and individual subscribers, administer or insure health benefits for nearly 100 million Americans. In most instances, the provision of these benefits is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*[1]

This case involves the appropriate standard of review in actions for judicial review of an ERISA plan administrator's discretionary benefits determination. More specifically, the Petition for Certiorari presents the question whether an ERISA plan administrator that both adjudicates and pays claims is operating under a conflict of interest that must be weighed on judicial review of a discretionary benefits determination. In granting the Petition, the Court additionally asked the parties to address the question of how any such conflict of interest should be taken into account on judicial review, in the event the Court does deem the conflict to exist.

As entities that administer and insure ERISA health benefits, Blue Cross and Blue Shield

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[1] In accordance with Rule 37.6, BCBSA certifies that counsel for a party did not author this brief in whole or in part and that no entity other than BCBSA, its members, or its counsel made a monetary contribution to the preparation or submission of the brief.

companies often have responsibility for both adjudicating and paying claims for benefits. Indeed, some of the decisions identified in the Petition that analyze the existence and effect of any perceived conflict of interest on the part of ERISA plan administrators adjudicating and paying claims have involved Blue Cross and Blue Shield entities. *See* Pet. 9-10; *see, e.g., Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990). Accordingly, BCBSA's members have a strong interest in how the Court resolves the question whether ERISA plan administrators that both adjudicate and pay claims operate under a conflict of interest and how any perceived conflict is taken into account (if at all) on judicial review of a discretionary benefits determination.

Counsel for Petitioner has submitted a letter to the Clerk of the Court consenting to the filing of all *amicus* briefs in this case. Counsel for Respondent has consented to the filing of BCBSA's *amicus* brief, as evidenced in the letter from Respondent's counsel accompanying this brief.

SUMMARY OF ARGUMENT

A. An ERISA plan administrator that both adjudicates and pays claims does not, merely because of that dual role, operate under a conflict of interest. Congress, through exceptions to ERISA's prohibited transaction rules, has permitted fiduciaries additionally to take on non-fiduciary functions. Treating plan administrators who occupy the dual roles of paying and deciding claims -- without more -- as somehow indicative of a conflict of interest is in tension with Congress's allowance for dual roles.

Nor does an assumed conflict of interest take account of the complexities or market realities of insurance. Using health insurance as an example, insurance can be, among innumerable other options, retrospectively rated, accompanied by reserves that balance risk, and experience rated -- all of which help negate the idea that a denied claim will automatically result in additional funds for an insurer. And market pressures, such as the need to satisfy employers who purchase their products, shield against insurers arbitrarily denying meritorious claims. Similarly, in plans where an employer self-funds (or self-insures) benefits, the employer may re-insure its risk or purchase stop-loss coverage, meaning that claims paid do not necessarily result in additional cost to it. The need to satisfy employees by providing promised benefits is also an overriding factor working in favor of an employer seeking to pay claims based on merit rather than denying them based on some purported financial interest.

Moreover, the courts have not found conflicts of interest in non-ERISA situations, where the claims decision-maker in some theoretical way stands to gain from a claims denial. In federal employee health benefits plans and under the Social Security and Medicare programs, the government makes final claims determinations, and claims denials can conserve the government's own funds or at least funds over which it is trustee. Yet, the courts have not perceived a conflict of interest and instead have deferred to agency decision-making because (as can be said in the ERISA situation as well) the decision-maker has valuable experience on interpretive issues.

B. Even if the Court deems a conflict inherent in a plan administrator's dual role, it should not adopt any special construct on judicial review to address such a conflict. ERISA already contains many safeguards against a plan administrator acting on the supposed conflict of interest. These safeguards include: rules requiring fiduciaries entering engagements with service providers (such as insurers) to examine the service providers' operational procedures; fiduciary obligations that preclude action based on self-interest and that are enforceable through powerful remedies; and regulatory claims requirements designed to ensure the full and fair review of claims.

Additionally, no special construct is necessary on judicial review because the customary abuse-of-discretion standard already captures all of the likely infirmities that decision-making based on conflicts of interest might be expected to engender. And finally, the Court should reject any special construct for judicial review of decisions by plan administrators with a dual role, given that the heightened scrutiny would prove difficult to apply. The complications heightened scrutiny would add to routine ERISA cases are not worth enduring, particularly given that the perceived conflict is more imagined than real.

ARGUMENT

I. AN ERISA PLAN ADMINSITRATOR THAT BOTH ADJUDICATES AND PAYS CLAIMS DOES NOT, MERELY BECAUSE OF THAT DUAL ROLE, OPERATE UNDER A CONFLICT OF INTEREST

The Circuit split on the questions before the Court has its genesis in *dictum* from *Firestone Tire*

& Rubber Co. v. Bruch, 489 U.S. 101 (1989), regarding the appropriate standard of review in actions for judicial review of discretionary ERISA benefits determinations. In *Firestone*, the Court held that "a denial of benefits challenged under [ERISA] . . . is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," in which case abuse-of-discretion review applies. *Id.* at 115. Though the Court ultimately directed *de novo* review in the controversy before it, the Court in *Firestone* then added instructions on consideration of an ERISA decision-maker's potential conflicts of interest under the abuse-of-discretion standard: "[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (quoting Restatement (Second) of Trusts § 187 cmt. d at 403 (1959)).

The Court's *dictum* in *Firestone* has, of course, led the Circuits to examine whether an ERISA plan administrator that both adjudicates and pays claims acts under a conflict of interest and, if so, how to take such a conflict into account. The answers to these questions have ranged from some Circuits concluding that the administrator's dual role does not result in a conflict of interest (*e.g.*, *Wright v. R.R. Donnelly & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005); *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999)), to other Circuits holding that it always does and that an elaborate shifting of

burdens of persuasion (*see Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566 (11th Cir. 1990)) or "sliding scale[s]" of scrutiny must follow. *Abatie v. Alta Health & Life Ins. Servs., Inc.*, 458 F.3d 955, 968 (9th Cir. 2006).

The correct answer to the threshold issue -- *i.e.*, whether a conflict of interest exists in the first place -- is that there is no conflict of interest when an ERISA plan administrator both adjudicates and pays benefits. ERISA's structure and terms do not support recognition of a conflict; deeming a conflict to exist does not comport with the market realities of insurance or self-funded plans; and the courts have not found conflicts of interest in the context of non-ERISA benefits programs, where a decision-maker has some connection to the entity responsible for paying benefits.

A. ERISA's Terms and Structure Do Not Contemplate the Finding of a Conflict of Interest

From ERISA's inception, Congress knowingly authorized the duality of settlor and fiduciary functions in single entities, an authorization inconsistent with a finding that the duality inevitably constitutes a conflict of interest. In its most simple form, a conflict of interest is a "real or seeming incompatability with one's private interests and one's public or fiduciary interest." *Black's Law Dictionary* 319 (8th ed. 2004). Certainly, Congress saw no such incompatibility between an ERISA plan's obligations to pay benefits and its administrator's fiduciary duty to adjudicate benefits claims properly.

In enacting ERISA, Congress, of course, sought to protect ERISA plan participants and their beneficiaries. *See Varity Corp. v. Howe*, 516 U.S. 489, 496 (1996). ERISA imbued standards of conduct and oath-like, professional obligations upon fiduciaries, while establishing an intricate network of remedies and sanctions for prohibited behavior and transactions. ERISA gives plan participants direct access to federal judicial review of potential controversies. One path to this review is through 29 U.S.C. § 1132(a)(1)(B), which permits a plan participant to bring a civil action to allege that benefits due have been denied. The plan participant also has the right to bring a civil action to allege a breach of fiduciary duty, under 29 U.S.C. § 1132(a)(2) and potentially under 29 U.S.C. § 1132(a)(3).

A particular facet of the ERISA regime is that it contains a detailed set of rules concerning prohibited transactions and an equally detailed set of exceptions to those rules. *See id.* §§ 1106, 1108. ERISA, in 29 U.S.C. § 1108(c)(3), makes a specific exception to allow a fiduciary to serve as an officer, employee, agent, or other representative of a party in interest while serving as a fiduciary. The legislative history notes that Congress permitted this "in recognition of established business practices. Thus a fiduciary could receive his normal benefits as a participant under the plan, could receive reasonable compensation for services and for reimbursement of actually incurred expenses, and could be an officer, agent or employee of an interested party." Staff of the Joint Comm. on Internal Revenue Tax'n, 93d Cong., *Summary of*

Proposal for Private Pension Plan Reform, at 24 (Comm. Print 1973).

The legislative history also notes: "The committee may wish to allow exemptions to be granted by the Secretaries of Labor and Treasury (jointly) only where needed so as to not unduly disrupt the established business practices of financial institutions (such as commercial banks, trust and insurance companies, and investment counsellors), which often perform fiduciary functions in connection with employee benefit plans." *Id.* at 55. This reason is mentioned again in a Senate Finance Committee Report, where the definition of a "party in interest" is also defined as:

> (1) managers (and employees) of the plan, (2) persons providing benefit plan services to the plan, (3) the employer and its officers, directors and highly compensated employees, and controlling or controlled parties, or parties under common control, (4) employee organizations (e.g., labor unions, including the national and international unions where a plan covers any local) with members covered by the plan, and officers and directors of those organizations and (5) fiduciaries who benefit other than in their capacity as plan fiduciaries from the particular prohibited transaction.

S. Rep. No. 93-383, at 100, 103 (1973).

Hence, Congress acknowledged the relationship a fiduciary may have to an interested party and approved of the dual role, which Congress acknowledged was an established business practice.

In its deliberation over exemptions to the prohibited transaction rules and how they might be established, there is no indication that Congress was concerned about this duality that it acknowledged existed. The duality is never even referred to as a conflict in a section of the legislative history that addresses conflicts of interest and fiduciaries:

> Transactions primarily involving conflicts of interest and fiduciaries --
>
> > The committee bill generally prohibits a fiduciary from dealing with the income or assets of a trust in his own interest or for his own account. However, this does not prohibit the fiduciary from dealings where he has an account in the employee benefit trust and the dealings apply to all trust accounts without discrimination.
> >
> > The bill also prohibits fiduciaries from receiving consideration in connection with a transaction involving the trust from any party who deals with the trust. This prevents, e.g., kickbacks to a fiduciary.

S. Rep. No. 93-383, at 99.

In the end, Congress implemented safeguards throughout ERISA to protect participants from actual conflicts of interest, safeguards that we point out later. *See supra* pp. 26-29. But Congress had little difficulty, and saw no conflict, in connection with a fiduciary also having non-fiduciary interests under an ERISA plan. The Court should not now

treat as an inherent, and suspicious, conflict of interest the dual role that Congress accepted.[2]

B. Deeming a Conflict to Exist Does Not Comport with the Market Realities of Insurance or Self-Funded Plans

The view that an ERISA plan administrator both adjudicating and paying benefits, without more, operates under a conflict of interest derives from an overly simplistic approach to insurance and plan funding and does not take into account how plans actually operate in the market. Under this view, the core postulates are that a plan administrator "incurs a direct expense as a result of the allowance of benefits, and it benefits directly from the denial or discontinuation of benefits." *Killian v. Healthsource Provident Adm'rs, Inc.*, 152 F.3d 514, 521 (6th Cir. 1998); *accord Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 437 (3d Cir. 1997). But such conclusions miscomprehend how insurance companies make money and disregard an employer's purpose in providing benefits. The *amicus*'s members are principally in the business of providing or facilitating the provision of health benefits; we therefore here focus particularly on the market realities and incentives associated with health insurance and the funding of health benefits.

ERISA health benefits plans can be either insured or self-funded. *See generally FMC Corp. v.*

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[2] ERISA can also take its cue from trust law. *See Varity*, 516 U.S. at 496. But even well-settled trust principles cannot override Congress's intent in ERISA. *Id.* at 497. In any event, Petitioner has ably shown that presuming a conflict in these circumstances is inconsistent with trust principles. *See* Petitioner's Br. at 23-26.

Holliday, 498 U.S. 52, 54 (1990). In both insured and self-funded plans, a single entity may be both the final decision-maker on claims and the payer of benefits. With insured plans, the employer decides to sponsor a plan and contracts with an insurance company (as permitted by ERISA; *see* 29 U.S.C. § 1002(1)) to bear the financial risk, process claims, and typically to make final benefits determinations upon appeal. In self-funded plans, the employer designs the plan and determines what benefits to cover, maintains some or all of the financial risk, and often hires a third-party administrator ("TPA") to process claims. *See* John C. Garner, *Health Insurance Answer Book*, Q 17:4, 17-2 and 17:11, at 17-4 (7th ed. 2006). In the typical self-funded arrangement, the employer will commonly establish a benefits committee to make final benefits determinations upon appeal. Even though the insurance company in an insured arrangement or the employer in a self-funded arrangement is ultimately responsible for making final claims determinations and paying benefits, neither would be acting in its *own* best interest by denying meritorious claims. In fact, the opposite is true: both have direct incentives to ensure that meritorious claims are paid.

1. *Insured Plans*. The decision to pay or deny an individual claim, even a large claim, is unlikely to affect the financial health of an insurance company. As a threshold matter, because many U.S. insurance companies today are multi-million or even multi-billion dollar [illegible] "the award in any one case will have only [illegible] effect on [the insurer's] operation[al] results." *Perlman v. Swiss Bank Corp.*

Comprehensive Disability Prot. Plan, 195 F.3d 975, 981 (7th Cir. 1999).

More fundamentally, the "indispensable characteristic of insurance" is the "spreading and underwriting of a policyholder's risk." *Union Labor Life Ins. Co. v. Pireno,* 458 U.S. 119, 127 (1982) (internal quotation marks omitted). For an insured benefit plan, the risk is spread across all covered members. The effect of risk distribution dilutes the impact of any specific claim and virtually eliminates self-interest based on the outcome of individual claims. "It is [a] characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it." 1 G. Couch, *Cyclopedia of Insurance Law* § 1:3 (2d ed. 1959).

Furthermore, under the risk-sharing designs and other pricing features currently prevalent in the insurance market, it is simply untrue that an insurance company has a financial incentive to deny claims. For instance, many plans are designed with retrospective rating. *See Perlman,* 195 F.3d at 981. Under these arrangements, the policyholder pays an estimated premium throughout the year, and at the end of the year, if claims paid were less than predicted, a certain percentage will be paid back to the employer. *See* Garner, *Health Insurance Answer Book,* Q 5:15, at 5-6. Conversely, if claim costs are more than predicted, the employer will owe an additional amount to the insurance company at the end of the year. *Id.* In such situations, it is the employer -- an entity not responsible, in the insurance context, for adjudicating claims -- that

may financially benefit from lower than anticipated claims payments or suffer financial loss from greater than anticipated claims payments.

Other arrangements may leave the risk of loss principally with the insurer, but set up a rate-stabilization reserve to "help offset the cost of a particularly bad year" and avoid "an otherwise large increase [that] might be called for at the next renewal." *Id.*, Q 5:18, at 5-8. The amounts necessary to establish a rate-stabilization reserve are figured into the premium calculations. With a rate-stabilization reserve, the insurer has diminished potential for a loss in the event it pays a claim, since the reserve may be available to cover the claim if the premium funds otherwise run out.[3]

Still another pricing feature illustrating that an insurer has no financial incentive to deny claims is experience rating. Under experience rating, an employer's premium rates are set based on the employer's own past claims experience. Garner, *Health Insurance Answer Book*, Q 5:24, at 5-9. As a result, the payment of fewer claims than expected lowers the following year's premiums and thus over time will decrease the insurer's funds. In this sense, the consequence of the denial of otherwise meritorious claims can be lower future premium income for the insurer.

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[3] In a fully insured plan, even without a rate-stabilization reserve, it can be expected that, if more claims were paid than anticipated, those funds might simply be recaptured the following year through a premium rate increase charged to the employer. Again, the consequence is that the payment of a claim does not inevitably translate into a loss for the insurer.

Not only do the complex features and pricing of modern-day insurance undermine the notion that insurers will make more money if they deny claims, the market protects against unwarranted claims denials. The U.S. insurance market is a highly competitive one. *See Rud v. Liberty Life Assurance Co. of Boston*, 438 F.3d 772, 775 (7th Cir. 2006). In the competitive environment, a reputation for "tight-fisted[ness]" is not a badge of honor for an insurance company. *Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005). As the First Circuit has explained, employers "desire[] to please their employees" through the ERISA plans they create. *Id.* at 75; *see also Chojnacki v. Georgia-Pac. Corp.*, 108 F.3d 810, 815 (7th Cir. 1997). If an insurer has a poor record of accuracy on claims payment, the employees will become disgruntled, and the employer will take its business elsewhere. *See Rud*, 438 F.3d at 775.[4]

As a final note on insured plans, to assume the person or department responsible for making claims determinations at an insurance company has responsibility for -- or is even cognizant of -- the company's budget is far-fetched. Insurance companies are large, complex, often multi-state or

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[4] It is also worth emphasizing that insurance companies are highly regulated entities. Under ERISA, the states largely retain their traditional role of regulating the business of insurance. *See* 29 U.S.C. § 1144(b)(2) ("[N]othing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . ."). Thus, not only would the market ensure against financially motivated denials of benefits, state regulators can be expected to seek to do the same.

even international entities. Unless the actual decision-making individuals have tangible incentives to act solely with an eye toward the company's bottom line, there is no reason to expect they would deny claims based on the company's self-interest. Indeed, quite to the contrary, companies have as much incentive to provide employees with bonuses for claim processing accuracy. They may do so because, among other reasons, inaccurate claims adjudication can (as mentioned) harm the insurer's reputation and, therefore, its competitive position. Inaccurate claims adjudication also ultimately can prove costly, for a claim denied without sound reason is more likely to be challenged in court, and the cost of litigation can often dwarf the benefits amount at issue.

In sum, a conflict of interest assumes there is a force separate from the merits pushing the conflicted party in a different direction. No such force is present with insurance. The structure of insured plans in today's market does not result in financial incentives to deny meritorious claims, but instead encourages accurate claims payment. Accordingly, there is no conflict of interest when the insurance company is both the adjudicator and payer of claims.

2. *Self-Funded Plans*. In a self-funded (or self-insured) plan, the employer acts as self-insurer and retains the risk in lieu of transferring it to an insurance company. *See FMC Corp. v. Holliday*, 498 U.S. at 54. The employer will often hire a TPA (which is permissible under ERISA's prohibited transaction rules, *see* 29 U.S.C. § 1108(b)(2)), that will process claims for a fee, but final claims decisions are usually decided by a committee established by the employer. Therefore, the

employer can be both the claims payer and final decision-maker, just as with an insurance company is in an insured arrangement.

In a self-funded plan, there is no financial incentive for the employer to act differently than the merits of the claim would require, and thus no conflict of interest. One of the primary reasons employers provide employee benefits is to assist with recruitment and retention. *See* 29 U.S.C. § 1001(a) (Congress noting, in ERISA, that employee benefits plans "have become an important factor affecting the stability of employment and the successful development of industrial relations"); *accord* Garner, *Health Insurance Answer Book*, Q 1:15, at 1-7. In fact, a primary reason the federal government -- the nation's largest employer -- established a health benefits program for its own employees was in order to assist "in the recruitment and retention of competent civilian personnel." H.R. Rep. No. 86-957, at 2 (1959). "Enlightened, progressive private enterprise almost universally ha[d] been establishing and operating contributory health benefits programs for its employees," and the federal government had previously made "scant progress" on this issue for its own employees, thereby harming its "competitive position" for the best talent. *Id.* Further, in addition to seeking to increase retention of talented workers, employers provide health coverage for employees to assist with productivity and to reduce absenteeism. *See id.* at 1-2.

In light of these purposes in establishing an ERISA plan in the first place, to then assume that an employer will deny for financial reasons in individual circumstances the benefits it has guaranteed in its plan makes the plan's creation a

futile act. In order to retain its employees, as well as to ensure their well-being and thus productivity, the employer has the exact opposite incentive: to pay the benefits to which the employee is entitled under the plan.

Indeed, if an employer did not want to pay claims, the employer could simply choose not to offer health or other welfare benefits plans. ERISA is a voluntary benefits system; employers are not required to provide benefits to their employees and are allowed to set up plans as they see fit. *See Hughes Aircraft Co. v Jacobson,* 525 U.S. 432, 444 (1999). The employer would not need to go through the charade of creating a plan that it would then administer so as to deny owed benefits, if its overriding intention was to save money. Instead, it could either decline to establish a plan in the first place or create one that was more limited in nature.

For a self-funded plan, as with an insured plan, a denied claim does not directly add to the employer's bottom line, and each paid claim does not subtract from the bottom line. Employers retain the amount of risk they can afford to bear and typically purchase insurance to protect themselves from additional loss. *See* John A. Appleman, *Appleman on Insurance 2d* § 102.7 (2d ed. 2000). For a small employer, this usually results in purchasing a fully-insured plan. A larger employer will probably have enough plan participants to spread the risk and will choose primarily to self-fund the plan and purchase a measure of insurance for protection in the case of catastrophic claims. That catastrophic protection is typically obtained through a "stop-loss" or reinsurance contract. *See* Garner, *Health Insurance Answer Book,* Q 17:52, at 17-21; Appleman,

Appleman on Insurance 2d § 102.3. There are generally two kinds of stop-loss coverage: specific and aggregate. Specific stop-loss will reimburse the employer if an individual participant's claims exceed a set dollar amount during the year, such as $1 million. Alternatively, aggregate stop-loss will reimburse the employer if total claims exceed an aggregate dollar amount in a given year, such as $10 million. Garner, *Health Insurance Answer Book*, Q 17:53, at 17-21.

Because of risk-spreading and stop-loss, even if a claim is significant, the employer with a self-funded plan is not likely to be harmed financially by paying a single claim. Either the affect of the claim will be diluted because the risk is spread across the plan participants or, if the claim exceeds what the employer was financially able to bear, the cost would likely be paid by stop-loss coverage. On this basis, a paid claim cannot simplistically be said to result in a company with a self-funded plan making less money that year.

And just as with insured plans, the employer may suffer greater financial hardship from denying a meritorious claim than paying the claim. No less than a reputation for tightfistedness harms an insurer's customer retention, an employer with a reputation for denying worthy claims will have difficulty retaining its employees; "employers have benefit plans to please employees." *Wright*, 402 F.3d at 74. The employer would also risk its own productivity by denying claims for needed medical services and thereby potentially contributing to absenteeism or the ill-health of the employee.

All of this serves to illustrate that it is simplistic to assume an insurer or employer operates under a

conflict of interest when it both determines and pays claims. A claim denied does not, given the realities and complexities of insurance and self-funded coverage and market features, equal a dollar earned.

C. The Courts Have Not Found Conflicts of Interest in the Context of Non-ERISA Benefits Programs, Where a Decision-Maker Similarly Might Be Perceived to Be Financially Harmed by the Payment of Benefits

There are numerous federal benefits programs in which the government both makes claims decisions and has some responsibility for benefits payments. Yet, the courts have not suggested that a conflict of interest exists; nor have they otherwise subjected government benefits determinations to special scrutiny. The same approach should govern where an ERISA plan administrator both adjudicates and pays benefits.

1. *Federal Employee Health Benefits.* A rough analogy to ERISA among federal programs is the health benefits program established by the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914. To that end, courts have sometimes "refer[red] to ERISA and FEHBA cases interchangeably." *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 394 (9th Cir. 2002); *see id.* (comparing FEHBA and ERISA preemption provisions).

Blue Cross and Blue Shield Plans administer, in conjunction with the Blue Cross and Blue Shield Association, and underwrite the largest FEHBA plan -- the "Government-wide service benefit plan." 5 U.S.C. § 8903(1); *see generally Empire HealthChoice*

Assurance, Inc. v. McVeigh, 126 S. Ct. 2121, 2127-28 (2006) (subrogation dispute involving Service Benefit Plan). While this, and other, FEHBA plans are insured products, *see Christiansen v. National Savings & Trust Co.*, 683 F.2d 520, 530 (D.C. Cir. 1982), the government can gain financially to the extent FEHBA-plan benefits are denied, and it can cost the government money when FEHBA benefits are paid. For example, many FEHBA plans are experience-rated, which means the government's costs in succeeding years increase as more claims are paid. *See* 5 U.S.C. § 8902(i). Many also have a feature that premium funds are held in the Treasury and disbursed on a "checks presented" basis (*i.e.*, as claims are incurred), leaving any remainder in reserves for use in subsequent years. *See* 48 C.F.R. § 1632.170(b)(2); *see generally Christiansen*, 683 F.2d at 529-31; *In re Bolden*, 848 F.2d 201, 203 (D.C. Cir. 1988). And Congress directed the federal agency overseeing the FEHBA program to be cognizant of financial costs to the government and to contain them aggressively. *See Doe v. Devine*, 703 F.2d 1319, 1329 (D.C. Cir. 1983) (FEHBA's "entire legislative scheme is based upon [the U.S. Office of Personnel Management] considering cost to the government in contracting for health benefit plans.") (internal quotation marks omitted).

While the government may stand to benefit financially from a particular result on a benefits claim under FEHBA, it also has final adjudicative authority in claims disputes. Under an administrative regime mandated in the FEHBA statute (5 U.S.C. § 8902(j)), and then implemented in federal regulations, the U.S. Office of Personnel Management ("OPM") makes final decisions on

disputed claims, subject then to judicial review. *See* 5 C.F.R. §§ 890.105, .107; *see also Empire*, 126 S. Ct. at 2129 (describing administrative procedure for disputed FEHBA claims).

In actions for judicial review of OPM's final decisions, the courts apply a deferential standard of review, without any qualification due to any purported conflict of interest that would result from the government's role as funder and final adjudicator for a particular FEHBA plan. *See, e.g., Muratore v. United States Office of Personnel Mgmt.*, 222 F.3d 918, 922-23 (11th Cir. 2000) (a court "will defer to OPM's interpretation as long as that interpretation is reasonable and relies on ample factual and legal support"); *accord Caudill v. Blue Cross & Blue Shield of N.C., Inc.*, 999 F.2d 74, 80 (4th Cir. 1993). By analogy, irrespective of whether an ERISA plan administrator -- not so differently than the government under FEHBA -- funds and adjudicates benefits, courts should not diminish the deference otherwise accorded the claims determination,

Moreover, the FEHBA decisions set forth reasoning for according deference that equally applies in ERISA situations. OPM's decisions enjoy deference, since "OPM does have relevant expertise in this area because it negotiates the contracts at issue and, pursuant to the FEHBA, routinely interprets plans to determine an insurance carrier's liability." *Muratore*, 222 F.3d at 923. ERISA plan administrators that both sponsor the plan and determine claims controversies likewise have knowledge pertaining to the negotiation (or creation) of the plan and have gained expertise on and understanding of plan terms through repeated

adjudications. That is so *only* because the plan administrator has the dual role of funding and determining claims. Absent the duties of sponsorship (including creation and funding of the plan), the plan administrator would be less expert on what the plan was intended to cover; and absent the obligation to determine claims, it could not bring its expertise to bear in final claims decisions. As in the FEHBA context, the dual role *supports* a deferential review, rather than results in a suspect conflict of interest.

2. *Social Security and Medicare Benefits*. Under both the federal Social Security and Medicare programs, the government bears responsibility for paying benefits and adjudicating claims. Deference nonetheless has been afforded to the government's claims determinations, without any qualification for a conflict of interest.

Under both the Social Security Act, 42 U.S.C. §§ 401 *et seq.*, and Medicare, 42 U.S.C. §§ 426, 1395 *et seq.*, benefits are paid from trust funds controlled and, for some benefits, subsidized by the federal government. *See* Social Security and Medicare Boards of Trustees, *Status of the Social Security and Medicare Programs: A Summary of the 2007 Annual Social Security and Medicare Trust Fund Reports* (available at http://www.ssa.gov/OACT/TRSUM/trsummary.html) (last visited Mar. 2, 2008). Of course, it is well-known that both programs face serious long-term financial difficulties that will require government "remedial action." *Id.* At the same time, the federal government, through the federal agencies responsible for administering Social Security and Medicare, makes final decisions on disputed claims under the programs, followed by

judicial review. *See* 42 U.S.C. § 405; 20 C.F.R. § 404.900.

Congress has provided that the relevant federal agencies' claims determinations for Social Security or Medicare benefits shall be "conclusive," unless devoid of "substantial evidence." 42 U.S.C. § 405(g). In applying that standard, the courts have held, without any concern for a conflict of interest, that the agencies' final determinations are reviewed under "a deferential standard," such that, "[l]ooking at the administrative record as a whole, we may overturn the Secretary's decision only 'if it is arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence, or contrary to law.'" *Chipman v. Shalala*, 90 F.3d 421, 422 (10th Cir. 1996) (quoting *Hennepin County Med. Ctr. v. Shalala*, 81 F.3d 743, 748 (8th Cir. 1996)) (Medicare); *accord Lax v. Astrue*, 489 F.3d 1080, 1084 (10th Cir. 2007) (Social Security).

This Court has gone a step further, finding that Social Security examiners do not act as advocates for the government simply because of their ties to it. In *Richardson v. Perales*, 402 U.S. 389, 410 (1971), the Court rejected an "implication of impropriety" with respect to the final decision of a hearing examiner considering a claim for Social Security disability benefits. The claimant complained that the "hearing examiner has the responsibility for gathering the evidence and to make the Government's case as strong as possible." *Id.* at 408-09 (internal quotation marks omitted). This Court said: "Neither are we persuaded by the advocate-judge-multiple-hat suggestion. It assumes too much and would bring down too many procedures designed, and working well, for a governmental structure of great and

growing complexity." *Id.* at 410. The Court held that the hearing examiner simply "acts as an examiner charged with developing the facts." *Id.*

Just as the courts have straightforwardly applied deference to Social Security and Medicare benefits determinations, without any concern that the decision-makers labor under some assumed conflict of interest, so should the Court find that the hearing examiner's counterparts under ERISA do not operate with conflicts of interest. As Judge Easterbrook has put it, "[w]e have no reason to think that the actual decisionmakers [for the ERISA plan] . . . approached their task any differently than do the decisionmakers at the Social Security Administration, and ordinarily deferential review is the order of the day." *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 981 (7th Cir. 1999).[5]

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[5] Another analogy suggested by Judge Easterbrook is to federal judges deciding cases important to the United States, which is a federal judge's employer. *Perlman*, 195 F.3d at 981 ("We have no reason to think that UNUM's benefits staff is any more 'partial' against applicants than are federal judges when deciding income-tax cases."). Consider a judge reviewing a multi-billion dollar tax matter prosecuted by the Internal Revenue Service. Even with the enormity of the federal budget, a significant tax matter can be of consequence to the United States. Yet, no special conflicts-of-interest analysis pertains where a judge's determination may have substantial consequence for the United States. Indeed, there was a time when this Court -- rather than looking suspiciously at a judicial determination in a large tax case -- was willing to do the exact opposite and accord special deference to the decisions of the United States Tax Court, due to its

II. EVEN ASSUMING A CONFLICT OF INTEREST DUE TO THE DUAL ROLE, SUCH A CONFLICT NEED NOT BE TAKEN INTO ACCOUNT ON JUDICIAL REVIEW OF A DISCRETIONARY BENEFITS DETERMINATION THROUGH ANY SPECIAL CONSTRUCT

Even in the event the Court deems a conflict to exist because an ERISA plan administrator bears responsibility both for paying and determining claims, the Court need not burden the judicial review process with any special construct to address it. First, ERISA and regulations implemented pursuant to it already fully protect against a plan administrator acting upon any perceived conflict. Second, the abuse-of-discretion standard, without any closer than typical scrutiny, would already require the invalidation of a decision in which a conflict of interest tainted the result. Third, application of a heightened standard would overly complicate ERISA cases, and the minimal nature of the conflict (if one is deemed at all to exist) would not -- on balance -- warrant the complications.

A. ERISA Already Includes Necessary Safeguards to Prevent An Administrator from Acting on a Potential Conflict of Interest

There is no need separately to address the purported conflict of interest on judicial review of discretionary benefits determinations, because ERISA includes multiple safeguards to ensure that

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expertise on tax matters. *See Dobson v. Comm'r*, 320 U.S. 489 (1943).

plan administrators will not act upon any potential conflict.

For instance, ERISA requires a plan fiduciary to ensure, before entering into a contract with a service provider, that the contract or arrangement is reasonable, the services are necessary for the establishment or operation of the plan, and no more than reasonable compensation is paid for the services; an arrangement that does not meet these requirements will not qualify for relief from ERISA's prohibited transaction rules. *See* 29 U.S.C. § 1106(a)(1)(C) (generally prohibiting the furnishing of goods, services, or facilities between a plan and a party in interest to the plan); *id.* § 1002(14)(B) (because a person providing services to a plan is considered a party in interest, the relationship between the service provider and the plan would constitute a prohibited transaction); *id.* § 1108(b)(2) (providing relief from the prohibited transaction rules for service contracts or arrangements between a plan and a party in interest that meet enumerated criteria).

Proposed Department of Labor ("DOL") regulations clarify that, in order for an arrangement to be considered reasonable, service providers must, among other things, disclose any conflicts of interest that may arise in connection with its services to the plan and the procedures that the service provider will implement in order to mitigate the conflicts. *See* 71 Fed. Reg. 70988, 71004-05 (Dec. 13, 2007) (proposed 29 C.F.R. §§ 2550.408b-2(c)(1), -2(c)(1)(C)-(F)). The fiduciary entering the transaction likewise has an obligation to weigh that information before entering the transaction. *Id.* These requirements are designed to create "an opportunity for service

providers to educate plan fiduciaries about how they address potential conflicts of interest." *Id.* at 70992.

Together, then, the current and proposed rules require -- at least where an ERISA plan purchases insurance -- close examination of the service provider's claims procedures and its processes for ensuring against the operation of any conflicts of interest. That examination must occur at the very inception of the insurance relationship.

Additionally, ERISA mandates that a fiduciary "discharge his duties with respect to the plan solely in the interest of the participants and beneficiaries" and "for the exclusive purpose of . . . providing benefits to their participants and their beneficiaries . . . and . . . in accordance with the documents and instruments governing the plan." 29 U.S.C. § 1104(a)(1). These obligations are enforceable through ERISA's remedies for breaches of fiduciary duty under 29 U.S.C. § 1132(a)(2)-(3). In that regard, ERISA authorizes the Secretary of Labor, or a participant, beneficiary, or fiduciary, to bring a civil action for equitable relief and, in certain cases, removal of the fiduciary, where a breach of fiduciary duty has occurred. *See id.* §§ 1109(a), 1132(a)(2). These enforcement tools already act as a powerful bulwark against a claims adjudicator deciding cases with an eye toward financial considerations rather than the participants' interests and the plan's terms.

The DOL has adopted detailed regulations aimed specifically at the claims procedures adopted by ERISA plans. The regulations require every employee benefits plan to establish and maintain reasonable claims procedures that must include, among other things, "administrative processes and safeguards designed to ensure and to verify that . . .

plan provisions have been applied consistently with respect to similarly situated claimants." 29 C.F.R. § 2560-503-1(b)(5). ERISA and the DOL's claims regulations require the administrator to provide claimants a full and fair review (*i.e.*, right to appeal) denied claims. *See* 29 U.S.C. § 1133(1); 29 C.F.R. § 2560.503-1(h)(2). The regulations still further require that a full and fair review in an appeal means an independent review, which does not afford deference to the initial determination, by a named fiduciary who is neither the individual who made the initial benefit determination nor the subordinate of such individual. *See* 29 C.F.R. § 2560.503-1(h)(3)(ii), -1(h)(4). Again, these regulations mitigate the prospect that any perceived conflict of interest arising from an ERISA plan administrator's dual role as adjudicator and payer of claims somehow will affect a claims decision on its merits.

The DOL regulations also require, if the initial determination is based on a medical judgment, that the fiduciary consult with an independent health care professional who was not consulted in connection with the initial determination and is not the subordinate of any such individual. 29 C.F.R. § 2560.503-1(h)(3)(iii), (v), and -1(h)(4). In addition, state laws often reinforce, at least with respect to certain types of health benefits plans, that an independent medical review must occur on claims involving medical judgment. *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 375 (2002) (finding that state law requiring health maintenance organization to seek and adhere to decision of outside medical reviewer was saved from preemption under ERISA's insurance saving clause, 29 U.S.C. § 1144(b)(2)(A)). If the Court were to insist on

heightened scrutiny because of a plan administrator's dual role, and if an independent reviewer has already confirmed the claims decision, a court would be closely scrutinizing a decision based on perceived conflicts that the independent reviewer's determination already confirms have not infected the decision.

B. The Abuse-of-Discretion Standard, Without Any Heightening, Would Necessitate Setting Aside Any Decisions Affected by a Conflict of Interest

In any case in which the perceived conflict of interest engendered by a plan administrator's dual role actually manifests itself in a claims decision, the abuse-of-discretion standard already would necessitate setting aside the decision. In *Abatie v Alta Health & Life Insurance Co*, 458 F.3d 955 (9th Cir. 2006), the Ninth Circuit noted that a conflict of interest would evidence itself in ways such as the administrator "provid[ing] inconsistent reasons for [the benefit] denial"; "fail[ing] adequately to investigate a claim or ask the plaintiff for necessary evidence"; "fail[ing] to credit a claimant's reliable evidence"; or "repeatedly deny[ing] benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of the evidence in the record." *Id.* at 968-969. The Solicitor General, at the Petition stage, added that a conflict might manifest itself in an "administrator den[ying] the claimant full and fair review of his claim, as guaranteed by statute and by the Department of Labor's claims regulations." Br. for the U.S. as *Amicus Curiae* Supporting Pet. for Cert. at 16.

But the abuse-of-discretion standard, without any heightening, would already capture each of these infirmities. Abuse-of-discretion review "is not a rubber stamp." *Herman v. Cent. States, S.E. & S.W. Pension Fund*, 423 F.3d 684, 693 (7th Cir. 2005). "The [plan] committee must articulate a rational connection between the facts found, the issue to be decided, and the choice made. Where the committee's interpretation of the plan defies all common sense, the district court must overturn that decision." *Dabertin v. HCR Manor Care, Inc.*, 373 F.3d 822, 828 (7th Cir. 2004) (citation omitted). There is plenty of room already in the abuse-of-discretion standard for setting aside any determination that allegedly contains inconsistent reasoning, is based on inadequate investigation, rejects reliable evidence, rests on supposedly indefensible interpretations of plan terms, is counter to the weight of the evidence, is -- under the DOL's rules -- procedurally defective, or in any other manner might be said to reflect decision-making tainted by a conflict of interest. *See Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833-34 (2003) ("[p]lan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician").

C. Application of a Heightened Standard Would Overly Complicate ERISA Cases

The Court should reject a heightened abuse-of-discretion standard to counter the assumed conflict of interest because determining when and to what extent to apply it would unnecessarily complicate judicial review of ERISA claims decisions. While Congress sought with ERISA "to offer employees

enhanced protection for their benefits," it did not seek to do so through "a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

In any system in which the heightened standard of review would govern, a court would face the threshold issue of determining whether the underlying plan actually was structured in a manner that created the perceived conflict of interest. In other words, would the plan administrator actually face a financial obligation in the event it determined benefits were owed? To answer that question, the court would need to consider whether, if the plan were insured, it was the type of insurance arrangement under which the insurer (if it made the claims decision) bore all of the underwriting risk for claims payments. If, for instance, the insurance contract were retrospectively rated, a decision to pay the claim might threaten no negative financial consequence to the insurer. Or was the insurer so large that the claim could not realistically be said to be a financial tug on the insurer? Was the plan self-funded, with reinsurance to soften the underwriting risk of the plan administrator? Was the plan funded entirely with employee contributions (rather than the sponsor's funds), so that the plan administrator's decision did not so overtly affect its own monies?

None of these questions would be answered from the administrative record created at the plan level, on which the court's review would be based. Instead, the reviewing court would need to convene a factual inquiry at the very start of each ERISA case to determine the type of plan at issue and the extent of

the perceived conflicts of interest. That inquiry alone could involve more resources and time than the review of the merits of the claims decision. When one considers that, at least in the health benefits context, there are millions of ERISA claims determinations annually (involving from the most minimal of consultations to expensive, cutting-edge procedures), and that ERISA cases already constitute a not insignificant portion of the federal courts' docket, the added work created by the new conflicts-of-interest analysis could overwhelm the federal courts.[6]

Once the reviewing court determined that a conflict of interest was potentially present, the court would then have to undertake the heightened review. The approach adopted by the Eleventh Circuit especially shows just how burdensome application of a heightened standard of review can be. Under its approach, a reviewing court first determines, *de novo*, whether or not the denial of benefits was "wrong." *Brown v. Blue Cross & Blue*

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[6] BCBSA itself, acting through a Committee, adjudicates ERISA long-term disability claims funded through an I.R.C. § 501(c)(9) trust for a majority of the Blue Cross and Blue Shield Plans. BCBSA's decision-making procedures under this program have been found to be free of conflicts. *E.g.*, *Ball v. Blue Cross & Blue Shield of Michigan*, No. 4:06-cv-2, 2007 U.S. Dist. LEXIS 4666, *18 n.3 (W.D. Mich. Jan. 23, 2007). Because of the distinction between such trust-funded benefits and the disability program at issue in this case, BCBSA believes any ruling aimed broadly at disability program adjudications should distinguish between programs of the type involved in this case and those that are trust funded as is the case with the program with respect to which the BCBSA Committee exercises claims adjudication duties.

Shield of Ala., Inc., 898 F.2d 1556, 1566 (11th Cir. 1990). If the denial was correct, the reviewing court affirms the administrator's decision; if it was wrong, the "burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest." *Id.* If the administrator meets that burden, the reviewing court then reviews the decision a second time to determine whether, despite being wrong under *de novo* review, the decision might survive under a deferential abuse-of-discretion standard. *See, e.g., HCA Health Servs. of Ga., Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 993-95 (11th Cir. 2001).

If this Court were to adopt a regime close to the Eleventh Circuit's approach, a reviewing court -- even if the most minimal of claims were involved -- might have to conduct *de novo* review *and* abuse-of-discretion review, and it would do so only after first completing the substantial task of determining in the first instance whether the plan's structure meant the claims decision-makers conceivably were operating under a conflict of interest. It is questionable whether that exhausting process is warranted even when a serious conflict of interest is at issue; but it more so unnecessary when -- as here -- the conflict is more imagined than real, is safeguarded through other ERISA provisions, and could otherwise be policed through application of a standard abuse-of-discretion inquiry.

CONCLUSION

The judgment of the Court of Appeals should be reversed.

Respectfully submitted,

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